Tuberculosis Skin Test Interview and Consent

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If not US, year of entry: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled outside of the US in the past 2 years? No \_\_ Yes \_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_\_

Today are you experiencing: Date of test #1 \_\_\_\_\_\_ Date of test #2 \_\_\_\_\_\_

* Cough (Unexplained or change from usual cough) yes no yes no
* Weight loss (Unexplained or with loss of appetite) yes no yes no
* Fever (Unexplained) yes no yes no
* Increased fatigue yes no yes no
* Chest pain yes no yes no
* Shortness of breath yes no yes no
* Night sweats (Unexplained) yes no yes no
* Do you have any health problems? List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ yes no yes no
* Are you taking any medicine regularly? List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ yes no yes no
* Have you had any immunizations in the past month yes no yes no

Have you ever:

* Had a skin (PPD) or blood test for tuberculosis? When?\_\_\_\_\_\_ yes no yes no
* Had a mark on your arm 2-3 days after the skin test? yes no yes no
* Been sent for a chest x-ray after the skin or blood test? yes no yes no
* Been told you have tuberculosis? yes no yes no
* Spent time with a person who had active TB? yes no yes no
* Had the BCG vaccine? yes no yes no
* Taken medicine for tuberculosis (latent or active) yes no yes no
  + What medicines did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + How long did you take the medicine? \_\_\_\_\_\_\_\_\_\_\_\_\_

I request and give permission for tuberculosis testing:

Signature for test #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature for test #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**------------------------------------------------For Office Use Only------------------------------------------------------------**

Test #1: TST Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_ Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Placed: Date: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_ Arm: \_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Read: Date: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test #2: TST Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_ Lot #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Placed: Date: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_ Arm: \_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Read: Date: \_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SC 3/31/23